CHAPTER VI

UTILIZATION REVIEW AND CONTROL

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INTRODUCTION

Under the provisions of federal regulations, the Virginia Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by recipients. Title 42 Code of Federal Regulations, Parts 455 and 456, mandates these reviews. The Department of Medical Assistance Services (DMAS) conducts periodic Utilization Reviews (URs) on all programs. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on Utilization Review (UR) and control requirement procedures conducted by DMAS.

COMPLIANCE REVIEWS

DMAS routinely conducts compliance reviews to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate provider. Title 42 C.F.R., Parts 455 and 456, mandates these reviews. Providers and recipients are identified for review by systems-generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group. An exception profile report is generated for each provider that exceeds the peer group averages by at least two standard deviations.

To ensure a thorough and fair review, trained professionals employed by DMAS review all cases using available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

Statistical sampling and extrapolation may be used in a review. DMAS may use a random sample of paid claims for the audit period to calculate any excess payment. When a statistical sample is used, the amount of invalid payments in the audit sample are compared to the total invalid payments for the same time period, and the total amount of the overpayment is estimated from this sample. Overpayments may also be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or as a result of any of the above problems, Medicaid may restrict or terminate the provider's participation in the program.

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. The program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable state and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to DMAS is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Program Integrity Section
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 East Main Street, 5th Floor
Richmond, Virginia 23219

Recipient Fraud

The Recipient Audit Unit of DMAS investigates allegations about fraud or abuse by recipients. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries.

If it is determined that benefits to which the recipient was not entitled were approved, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction a recipient who is convicted of Medicaid fraud by a court. That recipient will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Unit
Program Integrity Section
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

DMAS providers may refer Medicaid recipients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of DMAS. Referred recipients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See the "Exhibits" section at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate recipients on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, fax, or in writing. A toll-free HELPLINE is available for callers outside the Richmond area. An answering machine receives after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit
Program Integrity Section
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: 1-804-786-6548
CMM HELPLINE: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the recipient and a brief statement about the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

UTILIZATION REVIEW (UR) OF THE PROVIDER FOR ELDERLY OR DISABLED WITH CONSUMER-DIRECTION (EDCD) WAIVER SERVICES

The purpose of utilization review (UR) is to determine whether services delivered were appropriate, whether services continue to be needed, and the amount and kind of services required. Utilization review is mandated to ensure that the health, safety, and welfare of the recipients are protected and to assess the quality, appropriateness, level, and cost-effectiveness of care.

DMAS analysts conduct UR of all documentation submitted by the provider that shows the recipient's needs, available social supports, and level of care. UR is conducted on-site or as desk reviews, and will be unannounced. The UR is accomplished through a review of the recipient's record, evaluation of the recipient's medical and functional status, review of the provider qualifications, consultation with the recipient and family members, and a review of personnel records and billing records.

When the UR team arrives at the provider's place of business/offices, the team will request one record per team member in order to begin the UR process. The UR team will also request the provider to provide the rest of the records on the review list within two (2) hours of their arrival time for open records and by close of business on the arrival day for closed records.

During an on-site review, the analyst will review the recipient's record in the provider's/Service Facilitator's place of business/offices, paying specific attention to Plans of Care, supervisory notes (RN and Service Facilitator), daily records, progress notes, screening packages, and any other documentation that is necessary to determine if appropriate payment was made for services

rendered. The UR analyst will also meet or talk with at least one recipient or primary caregiver to determine recipient satisfaction with the EDCD Waiver services and the provider. The provider may be asked to assist in setting up this visit. In all cases, the primary caregiver is encouraged to participate in the DMAS review of the recipient's care.

During the review process, the analyst will be available to offer technical assistance and consultation to the provider regarding DMAS regulations, policies, and procedures. A letter will be sent to the provider within 30 days after the review is complete to either document the results of the review or provide an update on the status of the UR.

CONTENTS OF REVIEW

Providers are continually assessed to ensure that they conform to Medicaid participation standards and program policies. The provider is assessed on its ability to render consistent, high-quality care to a population in need of nursing facility level of care. Information used by DMAS to make this assessment includes DMAS desk review of the documentation submitted by the provider, as well as on-site review of the provider's files and interviews with staff and with recipients on visits to recipients' homes and via responses to quality assurance survey letters. DMAS bases its assessment of the provider on a comprehensive evaluation of the provider's overall performance in relation to the following program goals:

1. Recipients served by the provider meet the program's target population. The provider has a responsibility to be aware of the criteria for this program and to evaluate accordingly, on an ongoing basis, recipients' appropriateness for services. The provider must discontinue services, using the procedures outlined in Chapter IV, for any recipient whose condition does not meet the target population criteria.

2. Services rendered meet the recipient's identified needs and are within the program's guidelines. The provider is responsible for continuously assessing the recipient's needs through visits made by the provider and communication between the provider and other provider staff. The Plan of Care must be revised in accordance with any substantial change in the recipient's condition, and the recipient's record must contain documentation of any such change. This also includes the provider's responsibility to identify and make referrals for any other services which the recipient requires to remain in the home setting (e.g., durable medical equipment and supplies, skilled nursing visits, etc.).

3. The provider documentation must support all services billed to DMAS.

4. Services are of a quality that meets the health and safety needs and the rights of the recipient. Quality of care is best assured through an emphasis on communication and respect between the recipient and the assistant, and between the recipient and the provider who is responsible for the oversight of the Plan of Care. The quality of care is best assessed through communication with recipients. Some of the elements included in quality of care are:

    - Consistency of care;
    - Continuity of care;
    - Adherence to the Plan of Care; and
    - Health and safety needs of the recipient.

DMAS will review the provider's performance in all the program goal areas to determine the provider's ability to achieve high quality of care and conform to DMAS policies. DMAS is responsible for providing feedback to the provider regarding those areas that may need improvement. During reviews, DMAS will review recipient files and conduct home visits to assess the quality of care and continued appropriateness of services.

DMAS may visit a sample of clients in their homes to review the appropriateness, quality, and level of care received. If the Plan of Care is found to be inadequate, DMAS may change the hours or level of care. DMAS will evaluate the client's condition, satisfaction with the service, and appropriateness of the current Plan of Care.

REQUIRED DOCUMENTATION

Required Documentation for Recipient Records for Agency-Directed Personal/Respite Care

The provider shall maintain a record for each recipient. These records must be separated from those of other services, such as companion services or home health. If a recipient receives personal care and respite care services, one record may be maintained, but separate sections should be reserved for the documentation of the two services. The following information may be reviewed during the UR process:

- The Pre-Admission Screening Uniform Assessment Instrument (UAI); the Pre-Admission Screening Authorization signed by all members of the Pre-Admission Screening (PAS) Team (DMAS-96); the Screening Team Plan of Care (DMAS-97 or DMAS-300 for Respite Care Services); the MI/MR Level I Supplement for EDCD Applicants (DMAS-101A for all recipients with a diagnosis of MI or MR) and the Assessment of Active Treatment Needs for Individuals with MI or MR who Request Services Under the EDCD Waiver (DMAS 101B), if applicable; all provider Plans of Care (DMAS-97A/B); Supervision Request Form (DMAS-100); and all DMAS-122s;

- The initial assessment, documented on the Community-Based Care Recipient Assessment Report (DMAS-99) by the RN supervisory nurse completed on or before the start of care. This must be filed in the recipient's record two weeks from the date of the visit. (See Chapter IV for the content of the initial assessment.) Only the DMAS-99 can be used for nursing assessments. The Comprehensive Adult Nursing Assessment form or OASIS form is not acceptable;

- The provider staff's personnel files must verify that the minimum qualifications outlined in Chapter II are met;

- All RN supervisory notes (DMAS-99) completed and on file within two weeks of the date of the supervisory visit. Nursing notes must be in the recipient's record within two weeks of the last supervisory visit made to the recipient. Any supervisory visit not documented and present in the recipient's record will be considered as not having been made;

- Nursing notes must reflect all significant contacts with the recipient. It must be documented that the registered nurse has made a supervisory visit (with the aide present at least every other visit) in the recipient's home;

- The frequency of the RN supervisory visit must be conducted within the determined time that was agreed upon by the recipient and/or caregiver and documented by the RN on the DMAS-99. For more information on the frequency of this visit, see Chapter IV, SUPERVISION OF PERSONAL CARE AIDES: AGENCY-DIRECTED MODEL. If the recipient has a cognitive impairment as defined in Chapter IV, the frequency of the supervisory visit is at least every 30 days;

- The RN supervisor's documentation, using the DMAS-99, must include the observations of the recipient made during the visits as well as any instruction, supervision, or counseling provided to the aide working with the recipient. The RN supervisor's notes must also clearly document that he or she has discussed with the recipient or family member the appropriateness and adequacy of service. Client satisfaction with the services should be documented as well as all requirements for RN supervisor and documentation found in Chapter II of this manual;

- All provider contacts with the recipient, family members, health professionals, the pre-authorization contractor, DMAS, etc. All notes must be filed in the recipient's records within two weeks. Correction fluid must not be used to make corrections to the file. Any corrections made to the recipient's record must be initialed and dated;

- Provider Aide Record (DMAS-90) of services rendered and the recipient's responses. The DMAS-90 must be thoroughly completed. The DMAS-90 must document the care given and the times of arrival to and departure from the recipient's home each day the aide renders service. The aide and the recipient must sign the records weekly. In instances where the recipient is unable to sign and there is no family member or other legal representative to do so, the reason for the absence of this signature must be

thoroughly documented on the DMAS-90. The aides' weekly comments should note significant physical, social, and emotional aspects of the recipient's life that week. The DMAS-90 forms must be in the recipient's record within two (2) weeks; and

- If the recipient receives skilled respite services, a separate file must contain the forms, records, and necessary documents addressing respite services and authorization. These include:

  - Skilled Respite Record (DMAS-90A), signed and dated by the nurse and the recipient or family/caregiver. It must contain weekly notes on the recipient's care and status.

  - Respite Care Needs Assessment And Plan of Care (DMAS-300), only if respite is the sole service the recipient is receiving.

  - The RN supervisor's documentation using the DMAS-99.

  - A physician's order for skilled services using the CMS-485. The order must specify the skilled services that the LPN will render.

Required Documentation for Recipient Records for Adult Day Health Care (ADHC)

The following information may be reviewed during the UR process:

- The ADHC daily records (DMAS-302) must be thoroughly completed. The records must document the care given and the times of arrival and departure from the center each day. The records must be signed weekly by an ADHC professional. The staff's weekly comments should note significant physical, social, and emotional aspects of the recipient's life during that period. The weekly comment section must be completed unless that information is contained elsewhere in the recipient's record. The recipient's family must be sent a copy of the weekly records;

- The professional staff's 30-day progress notes should describe the recipient's medical/functional status, note any change in social support status, indicate any other services received by the recipient (to include personal or respite care services also under the EDCD Waiver), and reference a review of any rehabilitative therapy 30-day progress notes received;

- The original UAI, DMAS-96, DMAS-97, DMAS-101A (for all recipients with a diagnosis of MI/MR), DMAS-101B if applicable, and DMAS-301 must be in the recipient's record. The current and prior DMAS-122s and DMAS-302s must also be in the recipient's record;

- The professional staff's personnel files must verify that all staff meet the minimum qualifications outlined in Chapter II;

- The initial interdisciplinary Plan of Care (DMAS-301), all subsequent three-month interdisciplinary evaluations, and any changes to the Plan of Care must be in the recipient's record. The three-month interdisciplinary evaluation should indicate the reason for any change in the recipient's Plan of Care and state whether ADHC continues to be an appropriate long-term care service;

- All provider contacts with the recipient, family members, health professionals, DMAS, the pre-authorization contractor, etc. involved in the recipient's health care delivery. All notes must be filed in the recipient's records within two weeks. Correction fluid must not be used to make corrections to the file. Any corrections made to the recipient's record must be initialed and dated; and

- A copy of the recipient's living will and durable power of attorney (if applicable).

During the UR visit, DMAS may interview recipients in the provider's place of business/facility to evaluate the recipient's condition, satisfaction with the service, and the appropriateness of the current Plan of Care. The ADHC Center may be requested by the analyst to have the recipient's primary caregiver available for this interview. In all cases, the primary caregiver is encouraged to participate in the DMAS review of the recipient's care.

The UR staff will visit or talk to at least one recipient to review the appropriateness, quality, and level of care received. If the Plan of Care is found to be inappropriate, the analysts may change hours, level of care, or discontinue services. The analysts will evaluate the client's condition, satisfaction with the service, and appropriateness of the current Plan of Care.

Required Documentation for Recipient Records for Personal Emergency Response Systems (PERS) and Medication Monitoring

The PERS provider must maintain a data record for each PERS recipient at no additional cost to DMAS. The record shall contain the following and may be reviewed during the UR process:

- Delivery and installation date of the PERS and medication monitor;
- Enrollee/caregiver signature verifying receipt of the PERS, and medication monitor device, if applicable;
- Verification by a test that the PERS device, and medication monitoring if applicable, is operational, monthly or more frequently as needed;
- Updated and current recipient responder and contact information, as provided by the recipient or the recipient's caregiver;
- Physician's order for the medication monitoring unit;
- If the recipient has a medication monitoring unit, the recipient must also have documentation for a PERS device; and

- A case record documenting recipient system utilization and recipient or responder contacts/communications.

Required Documentation for Consumer-Directed (CD) Option

The CD Service Facilitator shall maintain a record for each recipient. These records must be separated from those of other services, such as companion or home health services**.** DMAS staff shall review these records periodically. At a minimum, these records shall contain:

- The Uniform Assessment Instrument (UAI); the Nursing Home Pre-Admission Screening Authorization signed by all members of the Screening Committee (DMAS-96); the Screening Team Plan of Care (DMAS-97); MI/MR Level I Supplement for EDCD Waiver (DMAS-101A); MI/MR Level II Supplement for EDCD Waiver (DMAS-101B); the Questionnaire used to Assess a Person's Ability to Independently Manage Personal Attendants (DMAS-95 Addendum); all CD Service Facilitator Plans of Care (DMAS-97A/B); and all Patient Information Forms (DMAS-122s). The current and prior DMAS-122s, for at least the last six months of services must be in the client's record. The "Exhibits" section of Chapter IV contains copies of these forms;

- The initial assessment by the CD Service Facilitator completed prior to or on the date services are initiated and filed in the provider record within five working days from the date of the visit. (See Chapter IV for the content of the initial assessment.) The example standardized form may be used to document the initial visit. (See the "Exhibits" section at the end of Chapter IV for a copy of this form.);

- CD Service Facilitator notes must be in the recipient's record within two weeks of the last supervisory visit made to the recipient. Any visit not documented and present in the recipient's record will be considered as not having been made. CD Service Facilitator notes must reflect all significant contacts with the recipient and document that the CD Service Facilitator has made a supervisory visit in the recipient's home at least every 30-90 days following the CD Service Facilitator's initial comprehensive visit. The CD Service Facilitator's initial comprehensive visit in the recipient's home must also be documented. The CD Service Facilitator's documentation must include the observations of the recipient made during the visits. The CD Service Facilitator's notes must also clearly document that he or she has discussed with the recipient or caregiver the appropriateness and adequacy of service. Recipient satisfaction with the services should be documented, as well as all requirements for CD Service Facilitators and documentation found in Chapter II of this manual;

- All CD Service Facilitator notes regarding contacts made between the CD Service Facilitator's visits. This includes the documentation of contacts with recipients or support systems when services cannot be delivered. Other contacts may be with the family, the physician, DMAS, the pre-authorization contractor, or other professionals. All notes must be filed in the recipient's file within five working days of the contact. Correction fluid must not be used to make corrections to the file;

- A copy of all Community-Based Care Recipient Assessment Reports (DMAS-99);
- All correspondence between the provider, the recipient, DMAS, and the pre-authorization contractor;
- Contracts signed by the recipient which document the recipient's choice of consumer-directed personal care services, choice of the CD Service Facilitator, and acknowledgment of rights, risks, and responsibilities associated with the program;
- Outline and Checklist for Consumer-Directed Recipient Comprehensive Training. This form must be completed with signatures and dates, and performed prior to the hire date of the personal assistant;
- The CD Service Facilitator's personnel file must verify that the CD Service Facilitator meets the minimum qualifications outlined in Chapter II of this manual; and
- Documentation to support billing of any services conducted by the CD Service Facilitator.

ANNUAL LEVEL-OF-CARE REVIEWS

The federal regulations under which waiver services are made available mandates that every individual receiving services be reviewed each year to assure he or she continues to meet level-of-care criteria for the waiver's targeted population.

Agencies will be required to submit documentation to DMAS each year to show the recipient's functional status and medical/nursing needs using the Level-of-Care Review Instrument (DMAS-99C), which will be reviewed by a DMAS analyst. DMAS will send the agency a letter each year indicating when that agency's level-of-care review is due and what documentation is required. For all agency-directed personal/respite care services, the level-of-care review must be completed by an RN. For all consumer-directed personal/respite care services, the level-of-care review must be completed by a Consumer-Directed Services Facilitator.

If it is found that a recipient no longer meets the level of care, DMAS will terminate services in accordance to the procedures detailed in Chapter IV of this manual.

DMAS can require repayment of overpaid money if agencies continue to serve recipients who do not meet the level of care without notifying the pre-authorization contractor of the change in level of care and the need for discontinuation of services.

MEDICAL RECORDS AND RECORD RETENTION

The provider must recognize the confidentiality of recipient medical record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern medical record use and removal and the conditions for the release of information. The recipient's written consent is required for the release of information not authorized by law. Current recipient medical records and those of discharged recipients must be completed

promptly. All clinical information pertaining to a recipient must be centralized in the recipient's clinical/medical record.

Records of EDCD Waiver services must be retained for five years from the date of service and not less than five years after the date of discharge. The provider must maintain medical records on all recipients in accordance with accepted professional standards and practice. The records must be completely and accurately documented, readily accessible, legible, and systematically organized to facilitate the retrieval and compilation of information. If the recipient is under 18 years of age, his/her medical records must be retained not less than seven (7) years. All EDCD Waiver medical record entries must be fully signed and dated (month, day, and year), including the title (professional designation) of the author.

PROVIDER PARTICIPATION STANDARDS

During the on-site review, the UR analysts will monitor the provider's compliance with overall provider participation requirements. Particular attention is given to staffing qualifications as described in Chapter II of this manual. The analysts will need to see all RN licenses and certificates of all aides who have provided personal care services, as well as work references (or proof in the personnel file of a good faith effort to obtain such references) and documentation of criminal background checks within 30 days of the date of hire. During this review, the analysts will discuss with the provider's administration, the provider's overall status as a Medicaid provider, any areas of concern, technical assistance needs, the plans for addressing those needs, and any recommendations the analysts may have.

FINANCIAL REVIEW AND VERIFICATION

The purpose of financial review and verification of services is to ensure that the provider bills only for those services which have been provided in accordance with DMAS policy and which are covered under the EDCD Waiver. The UR analyst will also ensure that the appropriate patient pay amounts, if any, have been applied. Any paid provider claim that cannot be verified at the time of UR cannot be considered a valid claim for services provided, and retraction of payment may be necessary. DMAS will send a letter of UR findings to the provider; attached to the letter will be a billing spreadsheet listing any incorrect billings found at the time of the UR, and the corrective action the CD Service Facilitator needs to take.

The provider should submit an adjustment as indicated within 30 days of the receipt of this form. If an adjustment is not received within 30 days, a reminder will be sent to the provider and an additional 30 days will be allowed for the adjustment of overpaid funds. If, at the end of this period, no adjustment has been made, DMAS will initiate a demand letter that requires the adjustment of overpaid funds to be made within 21 days. Failure to respond to this demand letter will result in DMAS recovery of funds from future provider remittances. Referral to the DMAS Post-Payment Review Section may be made.

Section 32.1-325.1 of the Code of Virginia requires that DMAS collect identified overpayments. Repayment must be made upon demand unless a repayment is agreed to by DMAS. Unless a lump sum cash payment is made, interest will be added to the declining balance at the statutory

rate pursuant to § 32.1-313 of the Code of Virginia. Repayment and interest will not apply pending appeal.

Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

Personal/Respite Care Services (Agency-Directed Option)

The Provider Aide Records (DMAS-90) must support the number of hours billed to DMAS. Only DMAS-90s will be used by DMAS to verify services delivered and billed to DMAS. No other documentation (i.e., time sheets) will be used for verification of services. If services billed to and paid by DMAS are not documented on the DMAS-90, DMAS will require the provider to refund Medicaid. (See Chapter V for billing procedures.)

For skilled respite care services, the Skilled Respite Record (DMAS-90A) must support the number of hours billed to DMAS. For respite performed by a personal care aide, the DMAS-90 must be used for documentation that services were rendered.

Adult Day Health Care (ADHC) Services

The ADHC Center's daily records on the Adult Day Health Care Daily Log (DMAS-302) must support the number of units billed to DMAS. Only DMAS-302s will be used by DMAS to verify services delivered and billed to DMAS. No other documentation (i.e., time sheets) will be used for verification of services. If services billed to and paid by DMAS are not documented on the DMAS-302, DMAS will require the provider to reimburse Medicaid. (See Chapter V for billing procedures.)

PERS

Billing for PERS must be supported by documentation regarding the installation of and training required to use the required device. Monthly billing for the ongoing monitoring services must be supported by documentation of at least monthly testing of the PERS device as well as documentation of each emergency signal which results in action being taken on behalf of the recipient.

Consumer-Directed (CD) Option

Documentation must support the number of visits billed to DMAS for services conducted by the CD Service Facilitator. CD Service Facilitator notes must document that the CD Service Facilitator has made a supervisory visit in the recipient's home at least every 30-90 days following the CD Service Facilitator's initial comprehensive visit. The CD Service Facilitator's initial comprehensive visit in the recipient's home must also be documented. Any visit not documented and present in the recipient's record will be considered as not having been made. If services billed to and paid by DMAS are not documented, DMAS will require the provider to refund Medicaid. (See Chapter V for billing procedures.)

EXIT CONFERENCE

Following the analyst's review of the records and home visits, the analyst will meet with the appropriate provider staff to discuss general findings from the reviews. The provider may include any staff the provider would like to attend, but must provide appropriate staff (as requested by the analyst) for this meeting.

The provider will be informed of the number of records reviewed, number of participants interviewed, general recommendations regarding level-of-care issues, general recommendations regarding changes in Plans of Care, and any pertinent information regarding documentation, service verification issues, quality of care, or provision of services. The provider is expected to use the findings of the UR to comply with regulations, policies, and procedures in the future. Records that have been reviewed shall not be altered to meet the compliance issues. The analyst will send a letter to the provider within 30 calendar days verifying that the review was conducted. This letter will also describe the findings of the review or will give an update as to the status of the review. This letter will also include a list of any retractions.

During the review process, the analyst will be available to offer technical assistance and consultation to the provider regarding DMAS regulations, policies, and procedures. If questions arise regarding compliance issues, the analyst will provide information and assistance. Any issues which, if uncorrected, might result in the termination of the provider contract will be presented in writing.

REIMBURSEMENT REQUIREMENTS

EDCD Waiver services that fail to meet DMAS criteria are not reimbursable. The following non-reimbursable items apply to all services and include all of the following, but are not limited to:

<u>General</u>

- PAS Team authorization not obtained prior to initiation of services;
- Request for pre-authorization of services not submitted by the provider within 10 days of initiation of services;
- In cases of retroactive eligibility, request for pre-authorization not submitted by the provider within 10 days of notification by DSS;
- Patient pay indicated on DMAS-122, but not indicated on CMS-1500 and paid by DMAS; and
- The recipient resides in a nursing facility, an intermediate facility for the mentally retarded, a hospital, an assisted living facility licensed by DSS, or an adult foster care provider certified by DSS.

Personal/Respite Care (Agency-Directed Option)

Additional non-reimbursable items for Personal Care include all of the following, but are not limited to:

- RN not qualified to provide services;
- No initial RN supervisory visit on or before the initiation of services;
- RN supervisory visit late – explanation not documented;
- RN supervisory visit is made outside of the guidelines established within the Plan of Care for individual recipients (i.e., beyond 30 days for individuals with a severe cognitive impairment);
- Personal care aide not qualified to provide services;
- Provider Aide Record (DMAS-90) does not contain the signature of the aide and caregiver/recipient – the reason for the absence of these signature(s) is not thoroughly documented on the DMAS-90;
- The DMAS-90 does not contain the arrival and departure time for each day of service;
- Hours/days of care provided exceeds authorized amount of hours/days – pre-authorization not obtained from the pre-authorization contractor;
- Inappropriate use of authorized hours not following the Plan of Care;
- No documentation of services provided and billed to DMAS;
- Current criminal history check not found in the employee's personnel file;
- Amount provider billed DMAS exceeded the amount of services authorized or verified; and
- The provider over-billed DMAS.

Respite Care

Additional non-reimbursable items for Respite Care include all of the following, but are not limited to:

- LPN not qualified to provide services;
- LPN providing respite care when the recipient does not have a skilled need;
- RN Supervisor visit late – explanation not documented;
- Record does not contain physician's order for skilled respite services and/or updated order every 6 months;
- Skilled Respite Record does not contain signatures, dates, and appropriate information for skilled services;
- Personal care aide performing skilled respite duties; and
- The provider over-billed DMAS.

Adult Day Health Care (ADHC)

Additional non-reimbursable items for Adult Day Health Care services include all of the following, but are not limited to:

- The ADHC Center does not have a current DSS license;
- The ADHC Center does not employ or subcontract with a RN who is licensed to practice in Virginia;
- The RN is not present at the ADHC a minimum of one day (eight hours) each month;
- Program aide is not qualified to provide services;
- Daily records do not contain the arrival/departure times for each day of service;
- 30-day progress note missing;
- Daily records are not signed or co-signed on a weekly basis by a professional staff member;
- Interdisciplinary staff meetings, to reassess each Medicaid participant and evaluate the adequacy of the Plan of Care, are not being held at least every three months; and
- The provider over-billed DMAS.

Personal Emergency Response System (PERS) and Medication Monitoring Unit

Additional non-reimbursable items for PERS and medication monitoring units include all of the following, but are not limited to:

- The provider does not meet the qualifications of a PERS provider as specified in Chapter II of the *EDCD Waiver Services* Provider Manual;
- Recipient does not meet criteria for PERS;
- the recipient is under the age of 14;
- the recipient is not alone for significant parts of the day or has a regular caregiver;
- the recipient does not require extensive routine supervision;
- someone else other than the recipient is in the home and is competent and continuously available to call for help in an emergency;
- the recipient's caregiver has a business in the home and PERS was provided when the recipient was not evaluated as being dependent in orientation and behavior;
- The PERS provider fails to document and furnish the Personal Care, Respite, or Adult Day Health Care provider(s) of the recipient a report for each emergency signal that results in action being taken on behalf of the recipient. This excludes test signals or other signals made in error;
- The recipient has a Medication Monitoring Unit, but does not have a PERS device;
- The recipient has a Medication Monitoring Unit, but there is not a current physician's order for the service; and
- The provider over-billed DMAS.

Personal Care (Consumer-Directed Option)

Additional non-reimbursable items include the following, but are not limited to:

- No initial comprehensive visit made by the CD Service Facilitator prior to the initiation of personal care aide services;
- No re-evaluation completed every 6 months;
- CD Service Facilitator does not meet the qualification criteria;
- No documentation of two visits within the 60 days of the initial comprehensive visit;

- Documentation does not support services billed to DMAS; and
- The provider over-billed DMAS.

PROVIDER SANCTIONS (ADVERSE ACTIONS)

The analyst will notify the provider of any overpayments or denials of reimbursement. An overpayment of reimbursement means that the provider will have to refund reimbursement that was paid inappropriately. A disallowance means that the provider will be prevented from billing for services, which were not in accordance with DMAS policy.

Pursuant to § 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate pursuant to § 32.1-313.1 of the Code of Virginia. Repayment and interest will not apply pending appeal. The DMAS Fiscal Division will coordinate the collection of any payments due to DMAS.

PROVIDER APPEAL PROCESS: UTILIZATION REVIEW (UR) DENIAL OF REIMBURSEMENT

Payment to providers of EDCD Waiver services may be retracted or denied when the provider has failed to comply with the established federal and state regulations or policy.

If the EDCD Waiver services provider chooses to appeal the request for overpayments or denials, they may request reconsideration. The request for reconsideration and all supporting documentation, must be submitted within 30 days of written notification of the retraction and/or denial to:

Supervisor, Waiver Services Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

DMAS will review the documentation submitted and provide the EDCD Waiver services provider with a written response to the request for reconsideration. If the decision to retract or deny is upheld, the provider has the right to appeal the reconsideration decision by requesting an informal appeal within 30 days of the written notification of the reconsideration decision. The provider's request should include all information as to why the overpayment or denial should not be made. The notice of appeal and supporting documentation shall be sent to:

Director, Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If the decision to retract or deny is upheld, the provider has the right to appeal the informal appeal decision by requesting a formal appeal within 30 days of the written notification of the informal appeal decision. The notice of appeal and supporting documentation shall be sent to:

Director, Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

RECIPIENT APPEALS

Reductions in service, suspensions, terminations, and denials may be appealed to the Department of Medical Assistance Services. Furthermore, an agency's failure to process a request for services within required time frames is an appealable issue. The recipient or his/her authorized representative must appeal the decision in writing within 30 days of the date of the decision notification. When filing an appeal request, it would be helpful to include a copy of the notice or letter about the action being appealed. Appeals should be directed to:

Director, Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

EXHIBITS

LEVEL OF CARE REVIEW INSTRUMENT

The assessment cannot be more than six (6)-months old.
(Use Instructions on page three to complete this form correctly.)

SSN #: _____ AIDS Waiver? ☐ Yes ☐ No Assessment Date (MM/DD/YYYY): _____

Last Name: _____ First Name: _____ MI: _____ Suffix (circle): Mr. / Ms./ Mrs.

Enrollee ID # (Recipient): _____ Age: _____ Enrollee Ph: ( ) _____

Provider ID #: _____ Provider Phone #: ( ) _____

If the recipient receives more than one service from your agency, you only need to fill out one form but list all provider numbers in the area above.

Enrollee Address: _____ City: _____ Zip: _____

WAIVER

Recipient Admission Date (Start of care date with service provider): _____ (MM/DD/YYYY)

☐ EDCD (*Specific service(s), check all that apply*): ☐ Personal Care ☐ Respite Care ☐ ADHC ☐ PERS

☐ CDPAS Personal Care ☐ CDPAS Respite Care

☐ AIDS (*Specific service, check all that apply*): ☐ Case Management ☐ Enteral Nutrition ☐ PDN

☐ Personal Care ☐ Respite Care ☐ Consumer-Directed

DEMOGRAPHICS (COMPLETE ALL SECTIONS)

Case Mgmt: _____ Transport: _____ Housing: _____ Congregate: _____ Marital Status: _____ Subst Abuse: _____

Home Repairs: _____ Com of Needs: _____ Personal Care: _____ Home Deliver: _____ Adult Protect: _____

Hearing Impaired: _____ Vocational: _____ Respite: _____ Home Health: _____

Adult Daycare: _____ Other Services: _____

FINANCIAL RESOURCES (CHECK APPROPRIATE BOXES)

Medicaid Insure: ☐No - 0 ☐ Yes - 1 Medicare Insure: ☐ No - 0 ☐ Yes - 1 Medicaid Pending: ☐ No - 0 ☐ Yes - 1

PHYSICAL ENVIRONMENT / FUNCTIONAL STATUS (CHECK APPROPRIATE LEVEL – ONLY 1 CHECK PER ROW)

ADLs (Check appropriate level)	Needs No Help 00	MH Only 10	Human Help Supervise 21	Human Help Phys. Assist 22	MH & Human Help Supervise 31	MH & Human Help Phys. Assist 32	Always Performed By Others - 40	Not Performed At All - 50
Bathing								
Dressing								
Toileting								
Transferring								
Eating/Feeding								

Continence (Bowel/Bladder)	Continent 00	Incontinent (Less than weekly) - 1	External Device/ Indwelling/Ostomy (Self care) – 2	Incontinent (Weekly or more) 3	External Device (Not self care) 4	Indwelling Catheter (Not self care) - 5	Ostomy 6
Bowel							
Bladder							

Mobility (Check appropriate level)	Needs No Help 00	MH Only 10	Human Help Supervise 21	Human Help Phys. Assist. 22	MH & Human Help Supervise 31	MH & Human Help Phys. Assist. 32	Confined Moves About 40	Confined - Does Not Move About 50

IADLs				
	Meal Prepare: ☐ N-0 ☐ Y-1	Housekeeping: ☐ N-0 ☐ Y-1	Laundry: ☐ N-0 ☐ Y-1	Money Mgmt: ☐ N-0 ☐ Y-1
	Transport: ☐ N-0 ☐ Y-1	Shopping: ☐ N-0 ☐ Y-1	Using Phone: ☐ N-0 ☐ Y-1	Home Maintenance: ☐ N-0 ☐ Y-1

PHYSICAL HEALTH ASSESSMENT (CHECK APPROPRIATE LEVEL)

Joint Motion

☐ Within normal limits or instability corrected – 0
☐ Limited motion – 1
☐ Instability uncorrected or immobile - 2

Med. Administration / Take Medicine

☐ Without assistance – 0
☐ Administered/monitored by lay person – 1
☐ Administered/monitored by professional nursing staff - 2

Orientation (Check appropriate box)	Oriented-0	Disoriented-Some Spheres/SomeTimes -1	Disoriented-Some Spheres/All Times-2	Disoriented-All Spheres/Some Times-3	Disoriented-All Spheres/All Times-4	Semi-Comatose /Comatose-5
Behavior (Check appropriate box)	Appropriate 0	Wandering/Passive Less than Weekly 1	Wandering/Passive Weekly or more 2	Abusive/Aggressive/ Disruptive Less than Weekly - 3	Abusive/Aggressive/ Disruptive Weekly or more - 4	Semi-Comatose to Comatose - 5

Ambulation	Needs No Help 00	MH Only 10	Human Help Supervise 21	Human Help Phys. Assist 22	MH & Human Help Supervise 31	MH & Human Help Phys. Assist 32	Always Performed By Others - 40	Not Performed At All - 50
Walking								
Wheeling								
Stair climbing								
							Confined Moves About	Confined D/N Move About
Mobility								

PSYCHO-SOCIAL ASSESSMENT (CHECK APPROPRIATE BOX)

Hospitalization or Alcohol/Drug Center: ☐ NO – 0 ☐ YES - 1

ASSESSMENT SUMMARY (CHECK APPROPRIATE ANSWERS)

Is there an informal caregiver? ☐ NO – 0 ☐ YES - 1 | Caregiver Support: ☐ Adequate - 0 ☐ Not Adequate - 1

If No Informal Caregiver or Caregiver Support Not Adequate – List backup plan:

Where does the caregiver Live? ☐ With client - 0 ☐ Separate residence, close proximity – 1 ☐ Separate residence, over 1 hour away - 2

MEDICAL / NURSING NEEDS (COMPLETE ALL SECTIONS)

Diagnosis: _____

Current Health Status/Condition/Comments: _____

Current Medical Nursing Need(s) – Check all items that apply:

1 ☐ Application of aseptic dressings (a)
2 ☐ Routine catheter care (b)
3 ☐ Respiratory therapy (c)
4 ☐ Therapeutic exercise and positioning (d)
5 ☐ Chemotherapy (e)
6 ☐ Radiation (f)
7 ☐ Dialysis (g)
8 ☐ Suctioning (h)
9 ☐ Tracheotomy care (i)
10 ☐ Infusion Therapy (j)
11 ☐ Oxygen (k)
12 ☐ Routine skin care to prevent pressure ulcers for individuals who are immobile. (l)
13 ☐ Care of small uncomplicated pressure ulcers, and local skin rashes (m)
14 ☐ Use of physical (e.g., side rails, poseys, locked wards) and/or chemical restraints. (n)
15 ☐ Management of those with sensory, metabolic, or circulatory impairment with demonstrated clinical evidence of medical instability (o)
16 ☐ Routine care of colostomy or ileostomy or management of neurogenic bowel and bladder (p)
17 ☐ Supervision for adequate nutrition and hydration for individuals who show clinical evidence of malnourishment or dehydration or have a recent history of weight loss or inadequate hydration which, if not supervised would be expected to result in malnourishment or dehydration (q)
18 ☐ The individual's medical condition requires observation and assessment to assure evaluation of the person's need for modification of treatment or additional medical procedures to prevent destabilization, and the person has demonstrated an inability to self-observe or evaluate the need to contact skilled medical professionals. (r)
19 ☐ Due to the complexity created by the person's multiple, interrelated medical conditions, the potential for the individual's medical instability is high or medical instability exists. (s)

 Recipient Name: _____

AIDS Waiver Only: AIDS/HIV diagnoses: ☐ Yes ☐ No

PC/RC - Weekly Hours: _____ ADHC - Number of Days Per Week: _____

Comments: _____

Signature of Person completing the DMAS-99C

Date the DMAS-99C was completed (MM/DD/YYYY)

Print legibly Name & Title

If this form is not being completed by the RN – Print legibly the name of the RN who made the referenced visit

INSTRUCTIONS FOR COMPLETING THE DMAS-99C

1. A copy of this form (DMAS-99C) must be completed in its entirety for each current waiver recipient that is admitted under your agency's Medicaid provider number. The instructions to fill out each category correctly are explained below. If you need further instructions about the meaning of a question on this form, look at the UAI manual located at: www.dmas.state.va.us.
2. The provider must attach a copy of the recipient's current: Provider Agency Plan for Personal & Respite Care (DMAS-97A), Consumer-Directed Services Plan of Care (DMAS-97B), the Adult Day Health Care Interdisciplinary Plan of Care (DMAS-301), or the AIDS Waiver Case Management Plan of Care (DMAS-114).
3. The forms are to be mailed to DMAS within the time frame designated on the cover letter. Each provider will receive a cover letter with a list of current recipients and a due date to mail all requested documentation. Due to HIPAA requirements, we cannot accept the forms through electronic mail. In addition, due to the volume, we request that you do not fax the documents, but send them through the U.S. Mail to: The Department of Medical Assistance Services
   F&HBSU – Level of Care Reviews
   600 East Broad Street, Suite #1300
   Richmond, VA 23219
4. **Assessment Date**: The date that the RN did the last 6-month Assessment that is being used to fill this form out.
5. **Waiver**: Check the waiver and the service(s) the recipient is receiving in the waiver.
6. **Demographics**: Place a Yes or No for the four following categories and the other categories not specifically listed below.
   Congreg: Does the client receive congregate meals outside the home? Yes or No
   Home Deliver: Does the client receive meals delivered to his home? Yes or No
   Hearing Impaired: Does the client have a hearing impairment of any type? Yes or No
   Transport: Does the client have current formal paid transportation? Yes or No
   Place the appropriate number following each of the three categories.
   Housing: 0-Own House; 1-Rent House; 2-House Other; 3-Apartment; 4-Rented Room
   Marital Status: 0-Married; 1-Widowed; 2-Separated; 3-Divorced; 4-Single; 9-Unknown
   Com of Needs: 0-Verbally in English; 1-Verbally in Other Language (write in language spoken); 2-Sign Lang/Gestures/Device; 3-Does not Communicate.
7. **Financial Resources**: Check the appropriate box.
8. **Physical Environment / Functional Status:** Check only one box in each category. (Do not write in comments in this section).
   ADLs: Check the appropriate box. Continence / Bowel & Bladder: Check the appropriate box.
   IADLS: Check the appropriate box. These items pertain to whether the client needs help in these areas.
   Mobility: Check the appropriate box.
9. **Physical Health Assessment:** Check the appropriate boxes. (Do not write in comments in this section).
10. **Psycho-Social Assessment**: Check appropriate box. (Do not write in comments in this section).
11. **Assessment Summary**: Check appropriate boxes. (Do not write in comments in this section unless explaining backup plan).
12. **Medical / Nursing Needs:** Describe the current health status/condition of the recipient and check the medical nursing need or write down the nursing need(s) of the recipient. Something must be checked to show recipient's Medical/Nursing eligibility.
    AIDS Waiver Only: Check the appropriate box. Aide's Weekly Hours: The number of weekly hours on the Plan of Care.
    Aide's Number of Days Per Week: The number of days a week that the Plan of Care schedules the aide to work.
13. **Comments:** Any information on the recipient's care, medical condition, or status that relates to his eligibility or utilization of hours.
14. **Reference:** Refer to Chapter 4 - exhibits of the Waiver Manual for eligibility criteria prior to completing this form.
15. **DO NOT leave sections blank - complete the entire form. Read and follow all directions carefully.**

 Recipient Name: _____